CCTP Experience at Scripps Health Care System

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Transition from Traditional Case Management to Care Management Model

CCTP is part of a broader initiative at Scripps

- **Navigators**: ED ⇨ Inpatient ⇨ Outpatient … ⇨ *Ambulatory*
- **Interdisciplinary Team**: MD + MTM Pharmacist + Navigator
- **Bedside Rounds**
  - **Goal boards** in room – patient friendly language
  - **Milliman Guidelines**™ utilized for goal LOS, D/C barriers
- **Follow patient for 30 days post acute care discharge** (CTI = ON)
- **Evaluation of outcomes:** LOS, Readmissions, Patient Satisfaction

Community Care Transitions Program

GOAL: Decrease 30 Day Readmissions for Medicare FFS Patients

FOCUS at Scripps:

- Increase Footprint + Documentation
- Understand Causes of Readmissions (Readmission RCA)
- Enhance Screening Capability

Increasing Footprint

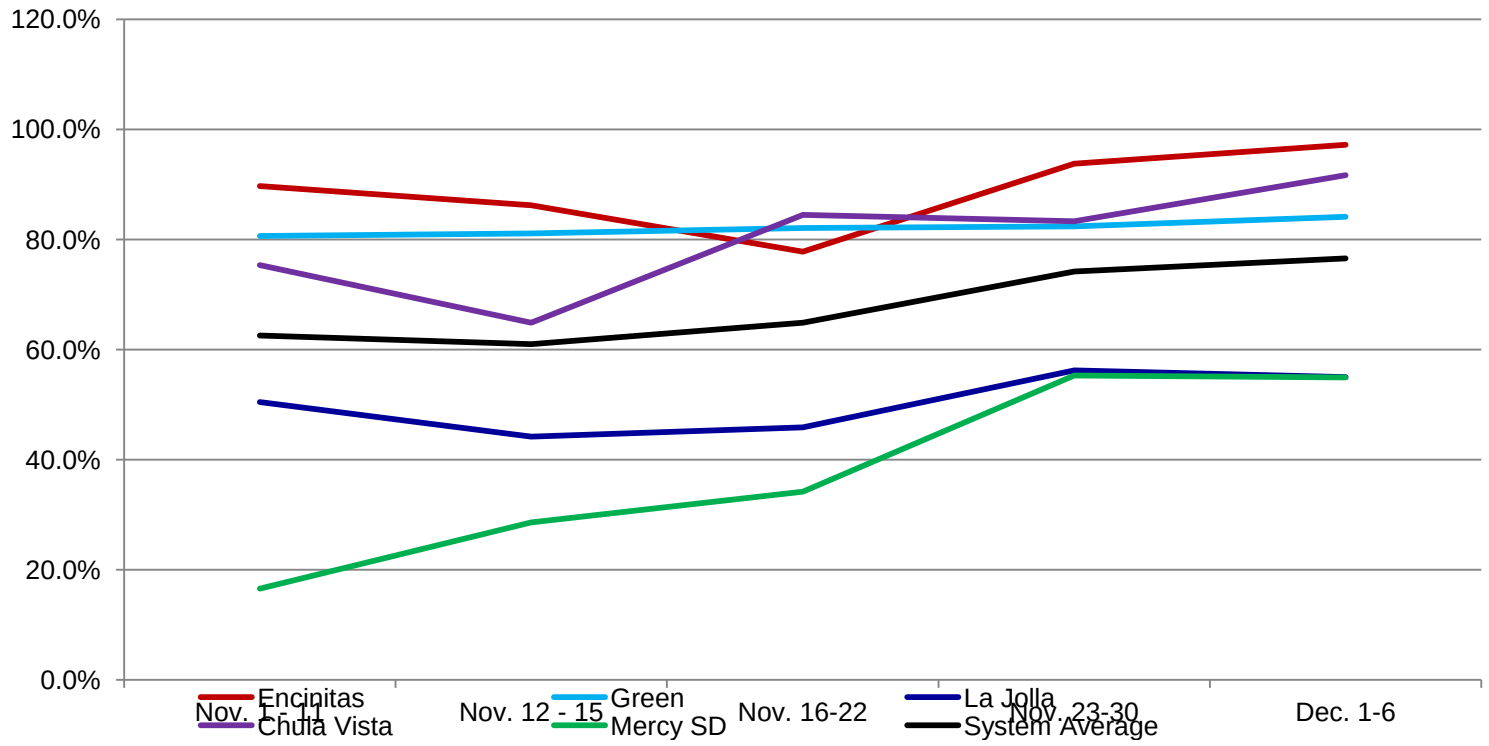
MONTH 2013	ENCOUNTERS
April	256
May	249
June	292
July	393
August	740
September	664
October	670
November	628

Target ~ 820 (+ 125) encounters/month

Staffing Changes

CCTP Footprint Tracking

	Encinitas	Green	La Jolla	Chula Vista	Mercy SD	System Average
Nov. 1 - 11	89.7%	80.6%	50.4%	75.3%	16.5%	62.5%
Nov. 12 - 15	86.2%	81.1%	44.2%	64.9%	28.6%	61.0%
Nov. 16-22	77.8%	82.1%	45.8%	84.5%	34.2%	64.9%
Nov. 23-30	93.8%	82.4%	56.2%	83.3%	55.3%	74.2%
Dec. 1-6	97.2%	84.1%	55.0%	91.7%	54.9%	76.6%



Readmission Root Cause Analysis (RCA) Process

Readmissions List Generated

CM / Navigator Interviews Patient in Real Time, Reviews Chart and discusses with MD/Pharmacist

Findings Entered into Common Midas Database

Quarterly Hospital Specific Data Review & Presentation to Site UR/UM Committee

Meeting at System Level 2-3x/yr to Review Trends and Identify Opportunities/Strategies

Decreased Readmissions!

30-day Readmission Root Cause Analysis (RCA)Initiative

Stats

Initial Study Period:	1/14/13-8/14/13
Total # of readmissions:	4,035
% of surveys completed:	60.5% (2,441)

Dr. Adam Ellis

Timing of Readmissions

Key Findings:

- Days 0-5 post-discharge most vulnerable: 33% of readmissions system-wide
- 55% of readmissions within 10 days of discharge (steady decline thereafter)
  - 80-89 year olds at greatest risk during 10 day window
  - Medicare A/B beneficiaries disproportionally affected during days 6-10
- Goal is for every high-risk patient to be discharged with 1 appointment in hand for follow up within 7 days of discharge
  - Pilot post-discharge ‘transition clinic’ at Scripps Encinitas

Ambulatory Care Follow-Up Prior to Readmission

Key Findings:

- 20+% of patients had not seen an outpatient physician prior to being readmitted
- 42.6% readmitted on days 6-30 post-discharge had not seen an outpatient physician
  - Medicare A/B patients disproportionally affected
- New survey to examine effectiveness of patients leaving the hospital with at least 1 follow up appointment in hand

Readmission Frequent Flyer Club

Key Findings:

- 21.5% of patients readmitted had 2 or more readmissions during the first four months of study
- Future analysis of ‘poly-readmitters’ (e.g. 3+ readmissions) by diagnosis, age and payer-type
- Higher level of care management for high-utilizers

Root Cause of Readmission

1/14/13-4/14/13
N= 971 surveys

Worsening illness:	35%
New Illness:	24%
Other:	19.1%
Medication related:	8.3%
Misc. (combined):	7.3%
Non-compliance:	6.3%

30-day Readmission Root Cause Analysis (RCA) Initiative

Successes

- Clear picture of:
  - who's coming back
    - age
    - primary coded diagnosis
    - primary payer
  - when they're coming back
  - how often they're coming back
  - follow up with an outpatient MD before readmission
  - readmission rates of top 5+ SNFs for each hospital
  - degree of readmission preventability

Challenges

- Initial survey:
  - root cause question not specific enough (e.g. 'worsening illness')
  - allowed use of 'other' as response
- Subjectivity of preventability designation
- Time constraints of Inpatient Navigators
  - some questions left blank
- Not digging deep enough

Enhancing Case Finding: 360Fresh

360Fresh ABC Dev Collaboration
Stuff with things

Identified Patients

Facility: All Payor:

Visits: ☑ All ☐ Current ☐ Discharged

Disease: ☐ HF ☐ AMI ☐ Pneumonia

Age: ☑ all ☐ < 65 ☐ 65+ ☐ 65-71 ☐ 72-79 ☐ 80+

Name: Selection: ☐ Selected Named: ☐ All ☑ Named ☐ Not Named

Rules

- ☐ Case Finding Screens
  - ☑ Chronic mental illness
    - ☐ Dual Diagnosis: Mental Illness & Substance Abuse
    - ☐ Mental illness (alone)
  - ☑ New Diabetes
    - ☑ Diabetes
  - ☑ Advanced Age or meets socioeconomic criteria
    - ☐ Advanced age
    - ☐ Socioeconomic criteria
  - ☐ Altered level of consciousness
  - ☐ Any mental illness
  - ☑ Cellulitis or IV infusion on DC
  - ☐ Chronic CHF, COPD, or DM
  - ☐ comorbidity form
  - ☐ Conservatorship
  - ☐ CVA / TIA
  - ☐ Funding challenges
  - ☐ History of 30d HOSPITAL readmission
  - ☐ History of frequent ED visits
  - ☐ HIV

Patients

Admitted: Sat, Aug 3 (1) — **Name: W (1)**

1 WILE, Coyote (000000109)
Loc:EICU, Gender: M, Age: 71yo

Admitted: Sun, Aug 4 (2) — **Name: M (1)**

2 MAN, Super (000000102)
Loc:EICU, Gender: M, Age: 83yo

Name: B (1)

3 BULLWINKLE, Moose (300000003)
Loc:5-11-7, Gender: F, Age: 103yo

Admitted: Mon, Mar 11 (1) — **Name: S (1)**

4 SMITH, Biggy (700000007)
Loc:EICU, Gender: F, Age: 76yo

Admitted: Wed, Feb 13 (1) — **Name: M (1)**

5 MCDONALD, Fona (900000009)
Loc:EICU, Gender: F, Age: 63yo

Admitted: Fri, Mar 1 (1) — **Name: P (1)**

6 PACER, Roxane (10460008261000023067)
Loc:EICU, Gender: F, Age: 69yo

Admitted: Tue, Aug 6 (1) — **Name: L (1)**

7 LANE, Lois (400000004)
Loc:103-2, Gender: F, Age: 73yo

Admitted: Fri, Aug 2 (3) — **Name: M (1)**

8 MOUSE, Mickey (000000106)
Loc:EICU, Gender: M, Age: 71yo

Name: D (1)

9 DUCK, Daffy (000000101)
Loc:EICU, Gender: M, Age: 81yo

Name: M (1)

10 MAN, Spider (000000104)
Loc:EICU, Gender: M, Age: 51yo

Admitted: Sat, Aug 3 (1) — **Name: R (1)**

11 RUNNER, Road (000000110)